North Shore VeinCenter

Mark Schwartz, MD, FACS, RPVI

Patient Medical History

Patient Name: _____ Occupation: _____

Email address: _____

Date of Birth: _____ Height: _____ Weight: _____

How did you hear about us? _____

Primary Care Physician: _____

How long have you had this problem (please estimate)? _____

Have you ever had treatment for your veins in the past? ⬭ Yes ⬭ No

if yes, please explain_____

_____

Please **check** if you have even been diagnosed with or treated for the following:

⬭ Deep Vein Thrombosis	⬭ Pulmonary Embolus	⬭ Phlebitis/Blood Clots
⬭ High Blood Pressure	⬭ Heart Disease	⬭ Hepatitis
⬭ Diabetes	⬭ Asthma	⬭ Lung Disease/COPD
⬭ Arthritis	⬭ HIV/AIDS	⬭ Bleeding disorder
⬭ Peripheral vascular disease	⬭ Heart valve disease	⬭ Stroke

⬭ Other _____

Have you ever been tested for or found positive for a Patent Foramen Ovale or Atrial Septal Defect?

⬭ Yes ⬭ No

Do you suffer from migraines? ⬭ Yes ⬭ No

Please **check** if you have recently experienced any of the following:

⬭ Night Sweats	⬭ Unexplained Weight Loss	⬭ Persistent Cough
⬭ Loss of appetite	⬭ Fever	⬭ Hemoptysis (coughing up blood)
⬭ Chest pain	⬭ Shortness of breath	⬭ Palpitations

North Shore Vein Center
One Hollow Lane, Suite 210
Lake Success, NY 11042

Tel: 516-869-VEIN (8346)
Fax: 516-773-6133
www.NorthShoreVein.com

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Have you had a Flu shot in the past 12 months ⬭Yes ⬭No

Have you ever had surgery? ⬭Yes ⬭ No

If yes, what type of surgery and when? _____

_____

Are you currently taking any medications? ⬭ Yes ⬭ No

If yes, please list all prescribed and over-the –counter, vitamins and herbals: _____

_____

Are your allergic to any medications/foods? ⬭ Yes ⬭ No

If yes, please list: _____

Do you have a **Latex allergy**? ⬭ Yes ⬭ No

Do you take any blood-thinning medication (e.g. Coumadin, Plavix or Aspirin)? ⬭ Yes ⬭ No

If yes, please list _____

Do you smoke? ⬭ Yes ⬭ Yes-but not anymore (stopped _____yrs ago) ⬭ No/Never

If yes, how many packs per day? _____

Do you consume alcohol? ⬭ Yes ⬭ No/Never

Is there a family history of blood clots? ⬭ Yes ⬭ No

If yes, please explain: _____

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Females Only:

Have you had a mammogram in the past 2 years? ⬭ Yes ⬭ No

Are you pregnant or trying to become pregnant? ⬭ Yes ⬭ No

Are you currently breast-feeding? ⬭ Yes ⬭ No

Are you taking hormones or birth control pills (ex: Estrogen, Progesterone or Tamoxifen)? ⬭ Yes ⬭ No

If yes, please list: _____

For how many years: _____

Over 65 years of age:

Have you had a recent Pneumonia vaccine? ⬭ Yes ⬭ No

PHYSICIAN ONLY

Left leg: GSV_____ SSV_____ AASV_____ Perforators_____

Right leg: GSV_____ SSV_____ AASV_____ Perforators_____

Blood Pressure: _____ / _____ Notes: _____

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